Building Stronger Communities Partnership

WIGAN

BUILDING STRONGER COMMUNITIES PARTNERSHIP

EXECUTIVE SUMMARY

DOMESTIC HOMICIDE REVIEW

INTO THE DEATH OF

Susan

Chair and Author: David Hunter

Supported by: Paul Cheeseman

Date: 1 August 2018

CONTENTS

1. THE REVIEW PROCESS

1.1 This summary explains the process undertaken by Wigan Building Stronger Communities Partnership domestic homicide review panel in examining the homicide of Susan who lived in their area.

1.2 The following pseudonyms, chosen or approved by the family, have been in used to protect identities.

Name	Who	Age	Ethnicity
Susan	Victim	42	White British
Roger	Offender	51	White British

1.3 Susan and Roger had been married for 20 years. Unbeknown to anyone outside of the household, including all agencies, Roger had a controlling nature which cause problems for Susan and their children. The marriage encountered additional difficulties in early 2014 resulting from Susan's knowledge of Roger's unsolicited advances to a female family member. Earlier in 2016 Susan informed Roger that she was having a relationship which she had ended. However, the liaison continued and Roger found out a few days before the homicide in autumn 2016.

1.4 Roger pleaded not guilty to murder. In April 2017 a jury found him guilty of murder and the court sentenced him to life imprisonment with a minimum

1.5 Wigan Building Stronger Communities Partnership considered the referral from Greater Manchester Police and initially decided not to hold a domestic homicide review because only one agency had any relevant knowledge and that was restricted to a GP appointment the day before the homicide. The trial ended in April 2017 and the decision not to hold a review was revisited. After further consideration the chair of Wigan Building Stronger Communities Partnership decided in late May 2017 that the criteria for a domestic homicide review were met. Thereafter new procurement arrangements further delayed the appointment of the review's chair and author. Coordinating diaries, combined with staff illness added to the time delay. The first domestic homicide review panel meeting was unable to be held until 25 September 2017.

1.6 In September 2017 Wigan Building Stronger Communities Partnership asked twelve agencies what information they held on Susan and Roger. Eight replied that they held no information relevant to a domestic homicide review. Four agencies held some information. One agency's return was relevant to the terms of reference. That was Wigan Clinical commissioning Group and that was minimal, but sufficient to construct an individual management review.

2. CONTRIBUTORS TO THE REVIEW

2.1 This table show the agencies who provided information to the review.

Agency	IMR[1]	Chronology	Report
Wigan Council Clinical Commissioning Group	Yes	Yes	
Bridgewater Community Healthcare NHS Foundation Trust	No	No	Short Report
North West Boroughs Healthcare NHS Trust	No	No	Short Report
Greater Manchester Police	No	No	Short Report

2.2 The Panel recognised that agencies held very little information on Susan and Roger. This is fairly unusual in domestic homicide reviews. The information they held was of limited use in trying to understand what happened to Susan.

[1] Individual Management Review: a templated document setting out the agency's involvement with the subjects of the review.

3. THE REVIEW PANEL MEMBERS

3.1 The table below shows the panel membership.

Name	Job Title	Organisation
Paul Cheeseman	Support to Panel Chair	Independent
Lauren Crews	Team Leader	Homes Wigan Council
Jill Cunliffe	Wigan Safeguarding Adult Board Business Support Manager	Wigan Council
Lynda Cunniffe	Named Nurse Safeguarding Children	Bridgewater NHS Foundation Trust
Kieran Davies	Domestic Abuse Operational Manager	Wigan Council
Lynn Fields	Enhanced Service Manager Children's Services	Wigan Council
Reuben Furlong	Assistant Director Adult Safeguarding	Wigan Borough Clinical Commissioning Group
David Hunter	Chair and Author	Independent
Margaret Jolly	Head of Adult Safeguarding	Wrightington, Wigan and Leigh NHS Foundation Trust
Sarah Owen	Service Manager Partnerships	Wigan Council
Heather Platt	Commissioning Matron	Wigan Borough Clinical Commissioning Group
Sarah Taylor	Probation Officer	Her Majesty's Prison and Probation Service
Alison Troisi	Detective Sergeant	Greater Manchester Police
Paul Whitemoss	Service Manager Safeguarding	Wigan Council
Nick Woods	Advanced Practitioner	North West Boroughs Healthcare NHS Foundation Trust

3.2 The Chair of Wigan Building Stronger Communities Partnership was satisfied that the Panel Chair was independent. In turn the Panel Chair believed there was sufficient independence and expertise on the Panel to safely and impartially examine the events and prepare an unbiased report.

4. CHAIR AND AUTHOR OF THE OVERVIEW REPORT

4.1 David Hunter was appointed as the Independent chair and author. He was supported by Paul Cheeseman. Both are independent practitioners who have chaired and written previous Domestic Homicide Reviews, Child Serious Case Reviews, Multi-Agency Public Protection Reviews and Safeguarding Adult Reviews. Neither has been employed by any of the agencies involved with this review nor are they connected to Wigan Building Stronger Communities Partnership who judged they had the necessary experience, skills and independence to undertake the review.

5. TERMS OF REFERENCE FOR THE REVIEW

5.1 These were set as:

The purpose of a DHR is to:[2]

a) Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims;

b) Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result;

c) Apply these lessons to service responses including changes to inform national and local policies and procedures as appropriate;

d) Prevent domestic violence and homicide and improve service responses for all domestic violence and abuse victims and their children by developing a co-ordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity;

e) Contribute to a better understanding of the nature of domestic violence and abuse; and

f) Highlight good practice.

Specific Terms

1. What indicators of domestic abuse, including coercive and controlling behaviour,[3] did you agency identify?

2. How did your agency assess the level of risk faced by the victim from the perpetrator, did it take into account all your agency knew about their individual and joint histories, including information from family and friends?

3. What services did your agency provided for the victim and perpetrator and were they timely, proportionate and 'fit for purpose' in relation to the identified levels of risk?

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[2] Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews [2016] Section 2 Paragraph 7

[3] The Serious Crime Act 2015 received royal assent on 3 March 2015. Section 76 of The Act creates a new offence of controlling or coercive behaviour in intimate or familial relationships.

4. How did your agency ascertain the wishes and feelings of the victim and perpetrator about their victimisation and offending and were their views taken into account when providing services or support?

5. How effective was inter-agency information sharing and cooperation in response to the victim and perpetrator and was information shared with those agencies who needed it?

6. How did your agency take account of any racial, cultural, linguistic, faith or other diversity issues, when completing assessments and providing services to the victim and perpetrator?

7. Did your agency comply with its domestic abuse policies and procedures and were any gaps identified?

8. How effective was your agency's supervision and management of practitioners involved with the response to needs of the victim and perpetrator and did managers have effective oversight and control of the case?

9. Were there any issues in relation to capacity or resources within your agency or the Partnership that affected your ability to provide services to the victim and perpetrator or to work with other agencies?

10. What learning did your agency identify?

11. Does the learning arising from this review appear in other reviews held by Wigan Building Stronger Communities Partnership?

12. What areas of good or innovative practice did your agency identify?

5.2 Timeframe under Review

The domestic homicide review examines events between:
1 January 2014 and 13 October 2016

6. SUMMARY CHRONOLOGY

6.1 Susan

6.1.1 The information about Susan was drawn from a family member and documents seen by the panel. Susan was born in Wigan and had two siblings all brought up by their parents locally. At the time of her death she worked in accountancy. Susan was always an anxious person which sometimes caused her to feel down. She suffered from social anxiety and reported she had poor confidence, which combined with anxiety made it difficult, although not impossible to find work.

6.1.2 Her family said, 'Our world has been turned upside down. It is hard to put into words what we feel. Susan was an independent lady, having taken a job after many years at home looking after the children. She was a happy lady, always looking on the bright side and she always believed in doing the best to make a happy home environment. We miss her every day.

6.2 Roger

6.2.1 Roger and his brother chose not to engage with the review and therefore the biographical details are very limited. Roger was born in the West Midlands and came to the North West as a young man. At the time of the homicide he was a warehouse manager. Prior to that he had periods of unemployment. At one point he held a firearms certificate before letting it lapse

6.3 The Relationship

6.3.1 The couple met when she Susan was in her early 20s and according to friends was 'swept off her feet'. They worked for the same company at this time.

6.3.2 They married in 1998, and had two children. The family moved to Canada in 2009 to begin a new life. Roger was unable to find work and they all returned to England about three months later. It appears Roger inherited money, started drinking heavily, became depressed and neglected his family.

6.3.3 In 2014 Roger attempted to kiss a female member of his wife's family. Susan found out and the couple decided to stay together. In 2015 Susan began a relationship with Mr Z. Susan later confided in a work colleague that she wanted to leave her husband but felt unable to do so because of her children. The reason for the separation was Susan's desire to start afresh with Mr Z because of Roger's controlling nature. This information was unknown by anyone until after Susan's death.

6.3.4 In April 2016 Susan told Roger that she had a relationship and that she had ended it. She did not tell Roger the name of the person. Susan told work

colleagues she was getting divorced and was planning to view a house to rent with Mr Z on the day she was murdered. In October 2016 Roger learned the identity of Mr Z and threatened him. Immediately before the homicide, Susan told Roger she was going to leave him.

6.4 Key Events

6.4.1 There was practically nothing known to agencies about the family. The following agencies submitted negative returns on matters relevant to the terms of reference.

- Greater Manchester Police
- Wigan Children's Services
- Wigan Adult Services
- Greater Manchester Mental Health NHS Foundation Trust
- Wigan Welfare Desk, Wigan council
- National Probation Service
- Addaction[4]
- Bridgewater Community Healthcare NHS Foundation Trust
- The Brick Project Wigan[5]
- Independent Domestic Violence Advocate Wigan Council

6.4.2 The following narrative sets out the few relevant events. Susan experienced episodes of anxiety for most of her adult life for which she received medication. There is little information contained within the GP record as to the cause or nature of Susan's anxiety other than it being described as a social phobia.[6]

6.4.3 During a 2005 consultation with psychology services for anxiety and depression, Susan told a health care professional that she had been happily married for seven years and had two children. Psychology concluded that Susan was able to maintain her own safe environment and that there was no evidence of being subject to ill-treatment/abuse including domestic violence.

6.4.4 She saw a GP on the day before her homicide and disclosed her relationship was under stress, but did not indicate the reasons. She agreed to self-refer to IAPT [Improving Access to Psychological Therapies] for further assessment as she was unsure whether cognitive behavioural therapy or counselling would best meet her needs.

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[4] Adult substance misuse treatment service

[5] The Brick is a charity which aims to support anyone who finds themselves homeless.

[6] Social anxiety disorder, also called social phobia, is a long-lasting and overwhelming fear of social situations.

7. FINDINGS

7.1 Susan and Roger had been married for 20 years, had a family and were working. Ostensibly they lived an unremarkable life and provided a safe and loving environment for the children.

7.2 No agency had any reports or suspicions of domestic abuse between them and Roger's successful application for a firearms certificate means that he was assessed as having a stable and non-violent nature at the time it was granted The panel looked for signs and symptoms of coercive and controlling behaviour but was unable to identify any, in fact the opposite was true. There is evidence that at one point Susan valued Roger's maturity and he was viewed as a considerate husband.

7.3 It is now known that Roger perpetrated domestic abuse through his controlling behaviour and attitude when drunk. His wife and children were frightened of him to such a degree that they would often remove themselves from his presence by leaving the house and driving to a public car park until Susan judged it was safe to return.

7.4 It is known from the homicide investigation that in 2014 Roger made an unsolicited, unwarranted and unwelcomed advance to a member of Susan's family. She found out and they couple decided to stay together.

7.5 In early 2016 Susan informed Roger that she was having a relationship with an unnamed male [this was Mr Z] and needed a break from Roger. He moved out of the family home in to a hotel. However they soon reconciled and agreed to continue their marriage. Roger believed the matter had ended. This was the second time the couple appeared to have overcome a crisis in their marriage. In early October 2016 Roger discovered Susan was still in the relationship with Mr Z.

7.6 On the morning of the homicide Susan went to work leaving Roger at home. At approximately 1000 hours Mr Z received a phone call from Roger who said, 'I'm coming for you and you are dead, it might not be today but I'm coming for you and I'll kill you'. That was not reported to the police until a few minutes before the homicide. These threats were repeated later that day and Mr Z reported them to the police. He also discussed them with Susan who decided to go home and discuss the threats with Roger.

7.7 According to Roger when he arrived home Susan was in the kitchen emptying the dishwasher. Susan and Roger began to discuss the situation calmly. According to Roger, Susan said, 'Anyway we're separating. I love him [Mr Z] more than you'. Roger said he grabbed Susan by the throat, took hold of a kitchen knife and stabbed Susan three times in the chest. Susan said, 'What you doing? I still love you'.

7.8 At 3.49 pm Roger contacted the Greater Manchester Police and during the conversation with the call taker stated, 'I need ambulance and police. I've just stabbed my wife. We've had a break up and I've lost it and stabbed her. I need and ambulance as quick as you can please". He later told an officer, 'I understand I didn't mean it I lost my temper'.

7.9 The panel carefully considered the issues in this review to determine whether anything could be learned from the circumstances of Susan's death. There was no evidence of domestic abuse in any of its forms known to anyone outside the family home.

7.10 His reaction to the final realisation that Susan had chosen another person over him, was the ultimate use of power without any known history of coercive control between them.

7.11 The sudden, or instantaneous, use of fatal violence has been observed in other domestic homicide reviews when couples meet for a final time at the end of the relationship. This case adds to the evidence that the risk to victims increases as such times.

7.12 However, that does not explain why Roger acted as he did when faced with what he probably saw as rejection. Most people in his circumstances deal with the facts without resorting to the extremist of measures. In some domestic homicide reviews offenders are reported as having said, 'If I can't have you no one will'. In this case there is no record of Roger saying that but his actions in killing Susan amount to the same sentiment.

7.13 The Judge's remarks were made after he heard all the evidence and perhaps show some insight into Roger's thinking.

'This was a murder of a woman in her own home where she is entitled to feel safe. I accept there was no pre-meditation. He did not go back home intending to kill … she decided to leave her unhappy marriage as she was entitled to do. She believed she would find greater happiness with another as she was entitled to do. This does not excuse, justify or simply mitigate his conduct in fatally stabbing her. He gave way to self-indulgence, verging on self-pity'.

8. LEARNING

8.1 Agencies

8.1.1 Wigan Borough Clinical Commissioning Group noted that if the GP had explored Susan's disclosure by way of routine or selective enquiry it is possible that the ensuing discussion would have served as a prompt to Susan to consider her own vulnerability and the GP would likely have considered a referral to appropriate support services.

8.2 The DHR Panel

8.2.1 There was very limited opportunity for learning arising from this review. What is known now that was not known in real time is that Susan was in a controlling relationship and sometimes left the house with the children when she felt unsafe.

8.2.2 The essence of this case was the hidden coercive and controlling relationship exercised by Roger. Susan knew that at times she had to leave the house with the children to stay safe. It is not known whether Susan recognised that she was in a controlling relationship or whether she knew or did not know where to go for help and advice.

8.2.3 In this respect there is some general learning around raising the issue of coercive and controlling behaviour as an element of domestic abuse and ensuring that domestic abuse strategies adequately deal with the issue including making it clear that services are available to people in coercive and controlling relationships.

8.2.4 While not knew learning, this review provides further evidence of two points.

1. The danger to victims increases at the point of separation
2. The recognition that coercive and controlling behaviour frequently features in domestic homicide reviews and is probably the most significant risk factor.

9. RECOMMENDATIONS

9.1 Agencies' Recommendations

9.1.1 Wigan Borough Clinical Commissioning Group was the only agency to make recommendations.

1. Consider introducing routine enquiry within general practice.

2. Feedback learning from DHR 6 to GPs and Practice Managers.

9.2 Panel Recommendations

1. That Wigan Council's Building Stronger Communities Partnership promotes across the work force and as part of its co-ordinated community response model, the need to recognise the escalation of risk at point of separation or relationship breakdown.

2. That Wigan Council's Building Stronger Communities Partnership works with children's services to recognise the heightened risk at times of separation or relationship breakdown and NOT as a protective factor when not supported by other factors.

3. That Wigan Council's Building Stronger Communities Partnership promotes the use of its approved screening tool in relation to coercion and control as either a single part of wider domestic abuse or as a form of domestic abuse in its own right as upheld in legislation.

4. That Wigan Council's Building Stronger Communities Partnership publishes this report and shares the learning with colleagues within the Borough and also across Greater Manchester.

5. That Wigan Council's Building Stronger Communities Partnership establishes whether there is a need for voluntary perpetrator programmes and if so to determine how they can be commissioned.

End of Executive Summary

Appendix A Action Plan

DHR 6 Action Plan

No	Recommendation DHR Panel	Key Actions	Evidence	Key Outcome	Lead Officer	Date
1	That Wigan Council's Building Stronger Communities Partnership promotes across the work force and as part of its co-ordinated community response model, the need to recognise the escalation of risk at point of separation or relationship breakdown.	Promote the use of the CCRM Toolkit across the partnership. The use of the CCRM Toolkit to be utilised when risk is escalated at the point of separation. This to be done using a range of methods – face to face training, newsletters, briefings, emails etc. Explore the development of an App for professionals to use via their smartphones	Evidence of training sessions attendance sheets, emails, briefings, newsletters If app is developed evidence of number of downloads	Frontline staff working across the partnership are aware of and utilise the CCRM Toolkit	Business Manager Domestic Abuse & Sexual Violence	April 2019
No	**Recommendation DHR Panel**	**Key Actions**	**Evidence**	**Key Outcome**	**Lead Officer**	**Date**
2	That Wigan Council's Building Stronger Communities	To ensure this learning is included in the next round of DVA Briefings.	Assessments will evidence increased risk and plans will be aligned to reduce	Increased victim confidence and satisfaction	Business Manager Domestic Abuse &	April 2019

	Partnership works with children's services to recognise the heightened risk at times of separation or relationship breakdown and NOT as a protective measure unless supported by other protective factors.	Complete a case file review of cases across children's services to ensure this risk is mitigated and evidenced in assessments and plans	this risk and increase family safety More assessments and case plans will have an improved input relating to the perpetrator on a whole family approach	Reduction of risk to children and families with safety planning clearly evident during these times in the victims journey	Sexual Violence Advanced Practitioner lead for DVA Children's Services	
3.	That Wigan Council's Building Stronger Communities Partnership promotes the use of coercion and control as either a single part of wider domestic abuse or as a form of domestic abuse in its own right as upheld in legislation.	To ensure this learning is included in the next round of DVA Briefings. Complete a case file review of cases across services to ensure this risk is mitigated and evidenced in assessments and plans.	Collate figures and data relating to the number of cases coercion and control is used. Relate this data to court outcomes and establish good practice	Increased victim confidence and satisfaction of the criminal justice sector Heightened feeling of victim safety and reduction of risk and vulnerability	Business Manager Domestic Abuse & Sexual Violence Partnership Business Analyst Victim Co-ordinator	April 2019
4.	That Wigan Council's Building Stronger	The report, findings, recommendations and action plan will be	The report and links will be published on	The learning and opportunities to learn will be public	Business Manager Children's and	Following approval from

	Communities Partnership publishes this report and shares the learning with colleagues within the Borough and also across Greater Manchester.	published via the Wigan Adults Safeguarding Board website. A link to the report will be published on the Greater Manchester Combined Authority website	the website	information enabling maximum reach	Adults Safeguarding Boards Safeguarding Boards	Home Office
5.	That Wigan Council's Building Stronger Communities Partnership establishes the whether there is a need for voluntary perpetrator programmes and if to determine how they can be commissioned.	Research current programmes and previous work across GM. Examine local need and any national evidence. Assess local funding and local commissioning processes	Evidence from recent Inner Strengths work and wider perpetrator programmes from across GM as part of Operation STRIVE will be assessed. Evidence from other areas across GM, commissioning their own programmes will be used too.	A decision whether there is a need for voluntary perpetrator programmes will have been made and if positive then a commissioning process will be underway.	Business Manager Domestic Abuse & Sexual Violence	April 2019

End of Executive Summary